

# Fatality Assessment and Control Evaluation (FACE)

## Baling Fatal Injury Facts

**In upstate New York, 2 workers died while operating balers and compactors between 2004 and 2005. Below are descriptions of how the workers were killed on the job.**

- A department store manager was killed when he was crushed in a cardboard baling machine. The safety gate was not closed during baling and the victim climbed into the baling chamber and was crushed by the hydraulic ram. The electrical wiring on the machine had been altered to bypass the "on/off" switch and the safety gate had been short-circuited.
- A recycling company employee was killed when he fell into a compactor while trying to clear a jam. The chute opening lacked fall protection and there was no emergency stopping device to prevent him from being pulled into the machine.



## How Can These Accidents be Prevented?

- Develop and implement a lockout/tagout program to ensure workers' safety during troubleshooting and machine maintenance.
- Train workers in proper baler operation and ensure employees know the importance of baler safety features, such as the safety gate and lockout/tagout program.
- Implement standard procedures for clearing material jams and provide safe access to feed chutes.
- Ensure only properly trained employees use baling equipment.
- Follow the manufacturer's recommended schedule for baling machine maintenance and inspection of machine safety features to ensure machines are working properly.
- Do not assign workers under age 18 to service, load, operate, or assist in the operation of baling equipment. New York State Labor Law prohibits workers under 18 from any occupation involving baler operation.

## New York Fatality Assessment & Control Evaluation (FACE)

The NY FACE program is supported by a grant from the National Institute for Occupational Safety and Health (NIOSH). Additional information can be obtained by contacting:

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